

School leavers with learning disabilities moving from child to adult Speech and Language Therapy (SLT) teams: SLTs' views of successful and less successful transition co- working practices.

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Abstract

School-leaving for pupils with long-term speech, language, swallowing or communication (SLSC) difficulties requires careful management. Speech and language therapists (SLTs) support communication, secure assistive technology, and manage swallowing difficulties post-school. UK SLTs are employed by health services, with child SLT teams based in schools. School-leaving entails transition from child- to adult-services. Little is known about the process, or how SLTs develop co-working across managerial boundaries. A qualitative study within one health board employing separately-managed child and adult SLT teams interviewed SLTs and analysed their views on successful and less successful school-leaver transitions. A critical incident approach elicited views on transitions that 'stuck in the mind', rather than typical instances, identifying supportive and risky co-working factors. Interviews were recorded, transcribed, checked, and thematically analysed. Three linked overarching themes emerged: SLT team remits and properties; communication and information exchange across SLT teams, and outside influences on teams. These applied to successful and less successful transitions, suggesting robust constructs along which SLTs evaluated transitions. Risk factors included unclear provision, pupils' earlier discharge by child SLTs affecting referral at school-leaving, and practical issues in accessing notes. SLTs used existing social-capital relationships to facilitate transitions. Implications for practice and ways of improving transitions are discussed.

Introduction

Transitions for school-leavers with long-term speech, language, swallowing or communication (SLSC) needs usually require a re-configuration of personal support service across health, social care and education, and a move from child to adult services, requiring careful multi-disciplinary and family liaison. Studies have reported variable success in arranging transitions at the end of school (Cullen et al., 2009, Right et al., 2015; SG, 2013). UK education legislation and resulting guidance provides information for education, health and other services on how and when post-school provision and support is to be planned (DfE/DoH, 2015 §8; SG, 2010a, §8). Where school-leavers have SLSC needs speech and language therapists (SLTs) are key actors in the transition process, involved in sustaining communication strategies, securing continuity of alternative/augmentative communication technology, and where necessary ensuring swallowing difficulty (dysphagia) continues to be well managed. UK SLTs are Allied Health Professionals (AHPs), mostly employed by the health service but with child team SLT spending much of their time in schools working with pupils and staff. Leaving school usually entails a move from a child to an adult SLT team, and it is important that effective transfer of care takes place. However, little is known about the process, nor how child and adult SLTs engage in within-profession co-working across managerial boundaries, although transitions had been noted as potentially risky for AHPs in the study site.

The present study aimed to identify and analyse relevant SLTs' views of factors influencing school-leavers' transitions from child to adult SLT services, and to support the development of good practice. The study took place within one Scottish health board (HB) that managed all NHS services within a large conurbation and

employed five separately-managed child and adult SLT teams involved with school leavers. Child SLT teams who worked with children in secondary schools liaised with school leavers and their families, school and local authority staff at all levels, paediatricians and other AHPs, organising in-school and home support. Adult SLT teams liaised with school leavers and their families, health

and social services, non- statutory further/higher education and ‘third sector’ charity/voluntary services to construct an appropriate programme of post-school support. Child and adult SLT services were therefore differently led, staffed and managed, and had different liaison partners, requiring positive action to work together and to smooth transitions across teams. Although the study took place in one health board in Scotland, similar child- adult service divisions are common across the UK and in other countries.

Transition policy for school-leavers in Scotland

The specific policy context frames practice, and so is outlined here. Scotland’s government, answerable to the Scottish Parliament, legislates for and implements health and education policy and aims to ensure co-ordinated and integrated service provision across the life-span. For children, this is codified in an overarching policy implementation programme, Getting it Right for Every Child (GIRFEC) (SG, 2012 a, ES, 2012; and see Coles et al., 2016). Scottish Government census data for 2014 (SG, 2015) show a highly integrated school service, where 96% of secondary school pupils with additional support needs spent all of their school time in mainstream classes, and only 1% spent no time there. Many school leavers are therefore transitioning from mainstream schools. SG (2015) lists 351 school leavers across the country identified with language or speech disorder in 2014. Eighty percent moved on to ‘positive destinations’ including further and higher education, training and employment. Some will be included in the Scotland-wide figure of around six per 1000 adult population with learning difficulties known to local authorities (SG, 2015 p.10). The study area is included within these national statistics.

In Scotland, children are recognised as having needs for additional educational support for issues related to permanent or temporary disabilities, and/or to social factors. The number of children identified as requiring additional support has risen from around 5% in 2009 to around 20% (Riddell and Weedon, 2016). Education policy as detailed in the Code of Practice (SG 2010 p.113) specifies that educational authorities (EAs) should identify pupils who will require support post-school at least twelve months before they are due to leave. Six months before leaving, the authority should have taken advice from and provided information to appropriate agencies, which includes SLTs if relevant.

Where two or more agencies are involved with a pupil (as is frequently the case), the Code states that an informed 'named person', usually a member of the school senior management team, should be appointed to liaise amongst services. (The Children and Young People (Scotland) Act 2014 (SG, 2014) has since extended the allocation of a 'named person' to all children in Scotland.) Timely co-professional working practices are enjoined.

Policy development for adults with long-term disabilities has aimed to enhance and improve services (SG, 2012b), culminating in a national strategy, *The Keys to Life*, (SG, 2013). However, there is recognition there that problems in accessing SLT services may occur post-school, as '*research shows that there is a marked reduction in the availability of services, e.g. speech and language therapy [...] once the person leaves full-time education*' [SG, 2013 p.104], and this is seen as problematic.

Health service policies also encourage co-working between SLTs and school services (SG, 2010b). As this guidance summarises, SLTs adopt a variety of roles in schools and other settings. They offer advice on good communication for all, and make suggestions for language and communication support activities generally useful to many. These roles do not require an SLT to open a duty of care for an individual. However, where SLTs design and monitor interventions for a named child or adult referred to their service, it is undertaken on an episodic basis. The SLT opens a time-limited 'episode of care' and provides and evaluate one intervention episode of pre-specified length and content. This applies to interventions delivered by SLTs and/or non-SLTs, such as school and other services' staff, support and voluntary sector workers, and other adults and families: many interventions involve several people. It also applies whether the intervention is delivered to an individual on their own or within a group. The duty of care will be closed at the end of the episode if the specified aims are achieved or if no further intervention is deemed appropriate, otherwise it will be renewed, perhaps with revised aims. Closing and not renewing an episode of care is in effect discharging an individual from SLT services, so that SLT case-loads only include individuals currently receiving intervention. Closing the duty of care also removes responsibility for negligence

from the SLT service if anything goes amiss with someone who has no duty of care open at the time, and transfers risk to those who are informed that the duty of care was closed. SLTs therefore inform families and other professionals (including schools) as relevant when an episode of care is opened and closed. This applies to child and adult SLT clients, but is not a way of working familiar to education, and school staff in particular may be unaccustomed to brief episodic approaches.

Individual SLTs therefore work within a large number of institutions, organisations and services with school leavers across public sectors with different customary practices, as well as across the school-leaving boundary. This complexity suggested a qualitative analysis of their expert opinion was required in order to identify issues that made school leavers' transitions successful or less successful in terms of their SLSC needs, and to suggest how both health and education sectors could further support school-leavers.

Aims and research questions

The study aimed to identify SLT co-working factors contributing to successful and less successful transitions for school-leavers moving from child to adult SLT services according to SLTs' perspectives, and to suggest improved practice where possible.

It therefore asked two research questions:

- what co-working practices did SLTs identify as contributing to successful or less successful school-leaver transitions, and
- what did their responses suggest for improving SLT co-working practice?

Methodology and Procedures

The project used a participatory evaluation paradigm (Smits and Champagne, 2008) with SLTs as respondents. Participant SLTs were asked at interview to specify their transition procedures, and to give an example of one transition they considered to be successful and another that was less successful: some chose to give fewer examples.

To ensure currency of information, participants discussed transitions completed thirty-six months or less before the start of the project. Participants were asked to explain why they considered each example to be successful or less successful, and what would have improved each transition. Encouraging respondents to focus on both a successful and a less successful transition followed a critical incident approach (Butterfield et al. 2005). This approach elicits 'outstanding' instances which may be infrequent in practice but which 'stick in the mind', rather than typical examples. It does not claim to represent usual practice, but to uncover helpful and risky factors considered by SLTs to be critical to outcomes.

Researchers

The first author was an academic member of the funding committee, and discussed the project with committee members who were SLT professional leads within the study HB. Both researchers were SLTs familiar with SLT clinical practice. This provided researcher credibility amongst participants, and facilitated access to potential respondents. Perspectives are therefore firmly grounded within the SLT profession.

Ethical approval

The researchers were advised by the HB research governance office that NHS ethical approval was not required for this evaluation project. Full ethical approval was applied for and received from the University of [anonymised] Ethics Committee. Participant information sheets were approved as part of that process.

Recruitment and participants

Only transitions between SLT teams within the study HB were considered, i.e. not those involving transfer to other HBs. SLTs were recruited via email or telephone through staff lists, checked and amplified with lists of SLTs held by the funder. Snowball techniques were also used, asking SLTs to suggest others to contact as potential participants in the study. The intention was to interview at

least one member of each relevant child and adult SLT team. Participant SLTs acted as willing volunteers who consented to involvement in the study.

At the start of the study, no list of SLT teams involved in transitions from schools, with their remits, staffing or service provision models could be located. Following discussion with HB SLT team- and professional-leads and early interviewees, five separately-managed child and adult SLT teams were identified. Two teams worked with children in secondary schools run by eight local authority education authorities. Three adult SLT teams serving different districts of the conurbation came from community health or health and care partnerships. Participant SLTs were then purposively sampled to include at least one from each of the five teams. Seven SLTs were interviewed, covering all teams, and discussed ten individual transitions.

Interview questions and interviewing

Interview questions were devised by the researchers and checked for suitability with relevant local SLT managers. Participants were asked to outline transition procedures used by their team, then to describe one transition that they considered had gone well. Background questions first confirmed that the transition to be discussed fell within the study remit (i.e. the school-leaver had SLSC needs and a learning disability, had left school in the last three years and transitioned for that reason, moving between SLT

teams within the HB); asked about associated clinical conditions, how the school-leaver was communicating, and who had helped them with the move. The SLT then described the transition they considered successful, and was asked what factors made them consider it successful, what factors were not so good, and looking back what they thought could have been done differently. They were then asked similar questions about a transition they felt was less successful, describing factors that made them consider it less successful.

Interviews took place between May 2013 and June 2014 at a location convenient for the participant,

including SLTs' workplaces and university premises, and lasted around 40 – 45 minutes. One researcher conducted all of the interviews, ensuring consistency of approach. Interviewees received the questions in advance of interview as part of the participant information package, but the interview was semi-structured, encouraging further comment and explanation. No prior themes were assumed, allowing an inductive, data-driven approach. Interviews were audio recorded and transcribed, and the transcript returned to the interviewee for checking and altering if they wished. The confirmed version returned was used for analysis. Participants were identified by a number to ensure confidentiality and data securely stored in line with university procedures.

Data analysis

Information on the associated clinical conditions of the school-leavers and the SLT team to which they transitioned (receiving team) were summarized (please see Table One).

Table One. School leaver transitions discussed: associated conditions and receiving adult SLT team

Associated conditions:	Transition to:
School leaver with cerebral palsy, communication and swallowing needs.	Community rehabilitation team.
Female school leaver with cerebral palsy, communication, eating and drinking needs.	Adult learning disabilities team.
Female school leaver with Down's syndrome, autism and severe learning difficulties, communication needs and dysphagia, behavioural issues and hearing impairment.	Adult learning disabilities team.
Male school leaver with autism, communication needs and challenging behaviour.	Adult learning disabilities team.
School leaver with dysarthria and dysphagia.	Community rehabilitation team.
Female school leaver with cerebral palsy and severe dysarthria but no learning difficulties.	Community rehabilitation team.
Female school leaver with cerebral palsy, communication needs and dysphagia.	Adult learning disabilities team.
Male school leaver with cerebral palsy, no learning difficulties and non-speaking.	Community rehabilitation team.
Female school leaver with deteriorating health condition and communication needs.	Community rehabilitation team.
Male school leaver with severe speech apraxia and moderate learning difficulties.	HB rehabilitation and assessment directorate SLT hospital team.

Open questions were analysed according to the principles of thematic analysis following the guidelines of Braun and Clarke (2006). The interviews and analysis were approached without preconception and there were no predetermined codes or themes. The datasets for the open questions were imported to NVivo. The research interviewer led the data analysis, developing familiarity with the data during interview, then transcribing, followed by many active readings of the transcribed data. During this process notes were made beside issues of potential interest in relation to each open question. Once a general sense of the content of a dataset associated with a question was achieved, sections relating to a common topic e.g. information exchange, team criteria for referral, were extracted, grouped together and coded. Where appropriate, sections were assigned to more than one code. A constant comparative approach was used within and across each potential code to establish its essence and boundaries. When all the data for a question had been coded, related coded topics were grouped together and regarded as themes. Once again a constant comparative approach was used to ensure the integrity of themes. For purposes of reliability, the second researcher checked 50% of the coded data then all of the data once it was assigned to themes. Names for the themes were chosen to represent the essence of their meaning. There was frequent discussion between the two researchers about intended meanings, assigning of codes and themes as the data analysis progressed. Extracts were repeatedly examined and re-contextualised to ensure the patterns emerging from the analysis were a true representation of the data. A preliminary thematic map was drawn up then repeatedly amended and refined by the two researchers, with the modification of some theme labels and the addition of over-arching theme groupings. Final agreement was reached that the analysis of the data and the resulting thematic map provided a full and appropriate representation of the data. Illustrative quotations were appended to each theme. The resulting report was

presented to the funding committee which contains senior SLTs from the study HB. They recognised the trustworthiness of the findings, further validating the results.

Results

Participants and transitions reported

The remits of the five teams were explored with respondents, to clarify the organisational structure that had been unclear at the start of the study. Discussion with respondents revealed that two city-wide child SLT teams worked with secondary schools, one specialising in autism. Three adult SLT teams served school-leavers with different clinical conditions. Two teams in different districts provided services for school leavers whose SLSC needs were associated with learning disabilities, and one community rehabilitation team provided services for individuals without learning disabilities who would usually have physical disabilities. Table One details the reported clinical conditions of the ten school-leavers discussed, their SLSC needs and the adult teams to which they transitioned.

Thematic analysis

Responses on transitions procedures, factors pertaining to successful and less successful aspects of transitions and what could have been done differently were subject to thematic analysis. Data saturation was reached with ten themes that comprehensively represented the coded data. Themes described factors related both to transitions reported as successful and those reported as less successful, suggesting they represented robust constructs along which SLTs evaluated transitions. The ten themes were grouped into three overarching inter-linked themes: SLT team remits and properties; communication and information exchange between teams, and outside

influences on SLT teams. Figure One charts these themes. Only themes specific to SLT cross-team working are discussed here, highlighted in bold type in Figure One, leaving aside themes related to transition outcomes (client response and progress) and working with non-SLT professionals and families.

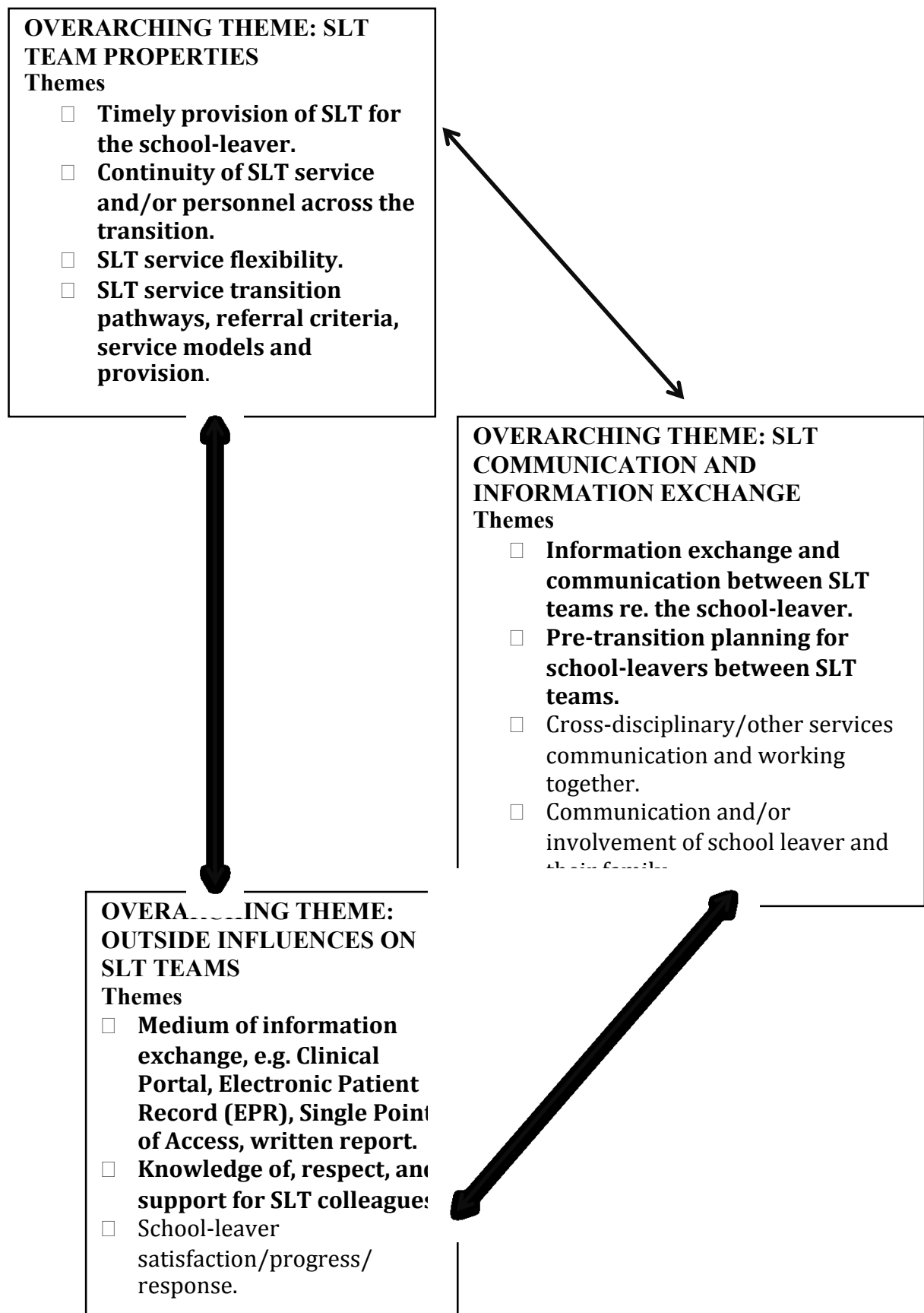


Figure One. Transitions between SLT Teams for school leavers: thematic map

SLT co-working themes highlighted in bold are discussed.

Themes are described below and illustrated by positive and negative quotations in italics. Authors' clarifications are in square brackets.

Overarching Theme – SLT team properties

This overarching theme related to team remits, i.e. who was eligible to receive their services and resulting referral criteria, their models of service delivery, and how these impacted on co-working.

This theme linked with the next overarching theme of information exchange and planning.

Successful transitions between relevant teams offered timely provision and continuity of service:

- *we knew them well in advance, received written information, written summaries and were able to put them on our waiting list – just waiting to be picked up as soon as they were discharged – so it was quite smooth and there wasn't any delay in the transition.*

However, adult team remits regarding clinical conditions were rather inflexible. SLT teams served individuals with learning disabilities or physical disabilities: where individuals had neither there were gaps in service. Thus a school leaver with a severe motor speech disorder:

... falls between criteria for different teams. ... Neither the adult rehabilitation service nor the learning disability service were able to accept this referral - [name] did not meet their criteria. Eventually the acute hospital [the rehabilitation and assessment directorate] took his case and were able to identify funding for his [new alternative communication] device and help him to understand how to use it functionally.

Team remits and referral criteria could also change:

- *the slight problem with our service [a community rehabilitation team] until very recently was we couldn't accept anyone unless they needed input from more than one discipline.*

This was no longer the case, but referrers would not all know this.

Difficulties also arose related to the episodic model of SLT working outlined above, with a short-term duty of care opened and closed. This was mentioned often as a fundamental issue. In many cases, child SLT teams had discharged pupils and so closed their duty of care long before school-leaving age, as their SLSC needs were being met adequately by school services. SLTs told schools of this and that no further SLT input was required. They thereby transferred the duty of care and the risk of not fulfilling it to the child's school as:

- *the people we have informed about what should be happening.*

Leaving school and its concomitant changes required SLSC needs to be re-assessed by SLTs, and often new support to be put in place. For this to happen, SLTs required a new referral, preferably to the appropriate adult SLT team. This required schools to

understand the health service model and the need to re-refer. However, one interviewee suggested that schools might not always understand the meaning of discharge and re-referral, as it was:

- *quite a complex one to get [the meaning] over.*

Other SLTs also reported that pupils' discharged status caused problems in co- working at transition:

- *because we [child SLT team] work in episodes and we don't work with children unless we're doing something for them - a lot of these children won't be known to us by the time they leave school - so that's where we have bit of a problem because they're not live cases when they leave school.*

As stated above, a senior member of school staff appointed as the pupil's 'named person' is responsible for co-ordinating and planning post-school support, including alerting relevant services such as an adult SLTs team. Some SLTs were also unsure whether all schools understood the

roles of the named person. A child team SLT reported:

- *there's a bit of me that wonders if schools realise their responsibility - certainly I always tell them it's their responsibility to pass on information [to adult SLT services] about eating and about communication, because we're therapists and we're involved when there's something that needs therapy, but once it's all done and set up we don't stay involved.*

Previous procedures used by child SLT services to remind schools of the need to refer at school-leaving had been abandoned in

- *previously, if a school leaver had past [SLT] input but not current input ... the school SLT [would] make sure that any past guidelines or finishing up plans or discharge recommendations were held and the school was aware that they had them... and the discharge report should say 'Please come back to this at the time of transition.' – and flag it up. ... Now if it just says ... 'No, they don't get SLT just now.' [So the named person thinks] 'OK, we'll not worry about it for the future.' I don't think that's enough.*
- *we [child team] used to have a very robust system where we used to find out which children were on the books and were leaving school and we would tell adult services – make sure paperwork got passed over. That was before we were re-designed into this sort of impact driven service and we were not able to keep children on as a precaution. I think this is right ... but it has made [transition] more difficult.*
- *there was a [child team transition] process to follow – there was paperwork to be completed – parents were informed that this was happening – we either just passed paperwork or we tried to have the opportunity to meet person to person as SLTs - either in a group or individually and that did work quite well for most children or for some children for a number of years – that has been given up on just now.*

Some child SLT had substituted paperwork with training for health and education staff on the need for re-referrals:

- *we've done training with school nurses about eating and drinking safely – how to re-refer and how to get help. We've got protocols in all the special schools about how to get help for eating and drinking and communication issues – so everybody out there has no excuse for not knowing.*

However, it was unlikely that all mainstream schools' management and staff had received such training and advice, or that they were clear about which adult SLT teams to contact. Lack of shared understandings of service models appeared to be a major risk factor in transitions, with implications for both school and SLT services. Suggestions about improvements related to (re)introducing or strengthening 'flagging' systems on child school records to remind named persons to alert appropriate adult SLTs teams, which will be discussed.

Overarching Theme: SLT Communication and Information Exchange

This overarching theme considered how, when and what information was exchanged between school SLT teams who had been responsible for the child in school and receiving adult SLT teams organizing post-school support. It links with the earlier theme of team remits, which affected information exchange and planning.

SLTs reported that they did not have formal written transition procedures, but relied on informal telephone or email information exchange. This was not reported as a problem:

- *these [procedures] are not necessarily a problem – they have always worked well as far as I am aware.*

Information exchange worked well for an adult team SLT who noted that in their service:

- *tThe procedure has been that the referring SLT will contact us well in advance, maybe in the middle of the person's final year at school, to give us the heads-up about them [the school-leaver] coming out [of the school system].*

However, as suggested above, information from schools was not always available:

- *legally transition planning should start at fourteen years re. needs assessment, funding, available adult service etc. But it is completely ad-hoc [whether the child is referred to SLT] – it does depend on somebody else.*

The 'somebody else' should be the named person, and as noted above they may not understand the need to include adult SLT services in transition planning.

However, difficulties arose, and there was confusion around referring to adult SLTs:

- *we [adult team] would get phone calls from our SLT colleagues [in child team] but often social work weren't aware of them or social work would make referrals to us and we weren't aware through [child SLT team] – so we were getting a myriad of different referrals coming from different areas and we weren't entirely sure which ones were appropriate for the service.*

When referrals were successfully received, and despite earlier discharge from child SLT services, some adult team SLTs wanted to receive information about the pupil's earlier SLSC needs and previous SLT interventions, to guide assessment and anticipate support needs, and to alert post-school providers in good time. Information

transfer could be successful or problematic. A successful example for an adult team SLT was where:

- *the school SLT gave me a lot of time to see [name of school leaver] in her classroom*

and to talk about her communication and her communication aid and to see her being supported to eat.

Information for adult teams could however be absent, or limited:

- *I [adult team SLT] have had absolutely no SLT information about her [school-leaver] – nothing even about her swallowing needs – and certainly nothing about her communication. That is because [the child SLT] team use Care Aims - in their view there has been no clinical risk for years.*
- *very limited information from [child] SLTs unless I chase it – I suppose I was expecting a big comprehensive report and I didn't get it – instead I had to chase information.*

Child team SLTs had not always been asked for or provided relevant information until they were contacted by non-SLT professionals:

- *but I [child team SLT] know they'll be at least a couple [of clients] that I either didn't know were leaving school or where things that were working in school will go pear-shaped The care providers will be on the phone saying 'The eating and drinking plan says this but we're not too sure if that is current 'cause you wrote it three years ago'.*

Lack of information was a particular concern where the school-leaver had swallowing difficulties, and required diet modification. An adult SLT reported:

- *I had absolutely no SLT information about her ... [The client's] down the Day Centre with no bit of paperwork. ... Yes, all right, she is at no risk at school because everybody knows her ... nobody knew her in the Day Centre – nobody would even have known that she couldn't eat a soft meal.*

There was also frustration that the transitions were predictable some time ahead:

- *we do or we should know these people are coming through the system so – why don't we have a list of names? Why don't we know – and why can't we start [transition] earlier and make it slightly easier for these families?*

Suggested improvements unsurprisingly again involved the need for reliable advance alerts for adult SLT teams about up-coming school-leavers.

Overarching Theme – Outside Influences on SLT Teams

This overarching theme described external factors that influenced SLTs teams but were not under the control of SLTs. One was how records were made available, which clearly links to the earlier theme of information exchange. The other was existing relationships amongst SLTs.

During the period of the research interviews, a major service development introduced electronic patient records. Access was available to some but not all SLTs through an online Clinical Portal. This development has since been extended, but at the time adult and child services had different access, and older records remained on paper.

- *the [adult SLT team] can use our [child SLT team's] database to find out whether a child is/has been known – we can't use their database but they can use ours. I believe when the electronic patient records come in that will be easier. [Now] the acute service is not on the same system so it won't tell us when children are in hospital for instance. ... Community services (that's health and social work) will be able to tap into the same records but not acute [NHS services].*

Easier access was expected to reduce the burden for child SLT services accessing stored paper records for discharged children, in order to provide information for receiving adult teams:

- *... adult teams pick up people that we've [child SLT team] seen in the past and then*

we've got to go and find the notes and find out what we last did.

and for adult SLT teams requesting information:

- *so we just phone up the [child] SLT and ask 'Can you send a report?' and that depends on where the case notes are – you spend a lot of time making phone calls and doing that kind of bureaucratic work.*

Respondents welcomed these development as they facilitated access, and further improvements were anticipated.

The SLT service in the study area had a relatively stable workforce. No negative comments were recorded about relationships amongst SLTs, and SLTs reported using

personal knowledge and good existing working relationships with colleagues to smooth transitions:

- *I have in the past had the opportunity to meet with an SLT [receiving adult team SLT] at that last review meeting and that gave a more personal link if you like.*
- *we [adult team respondent and colleague] have both been here for quite a while now, and our colleague on the paediatric side's been here for quite a while, so we know who each other are now - so it works quite well. We can just make a phone call and say 'Have you heard of this person?' And vice versa - she [child SLT] will phone us up – 'This person's coming your way, can you transfer reports over?'*

Co-location with relevant staff also helped informal communication:

- *the adult rehabilitation team and SLT for [the school leaver's] area happens to work here [at child Team SLT's work place] some of the time - so it was a face-to-face on a very regular basis. That was exceptional - that's what made it exceptionally good for me because I could talk her [SLT]*

through all of the information and the anecdotal information that sometimes contributes to how families are going to be able to support children.

- *it's worked better since we [child team SLTs]ve been co-located with adult learning disabilities [team] - the fact that we can actually talk to each other without jumping through red tape. They don't have an SLT at the moment, but when [name] was their SLT - in the same corridor – [name] would just come along and say 'Have you heard of this person?' or [name] would go to our clerical officer and ask 'Is this person on the books'?*

However, these relationships were recognised as individual and fragile, vulnerable to staff and location changes and service re-organisations. There was no evidence of - team building development activities:

- *I [adult team SLT] know the paediatric SLT who works in the area – the SLT who mostly works with the more complex cases - so I know where to find her. If she left it would get more difficult - I wouldn't know in terms of managers or team leaders. It is a personal connection - contact that you've made over the years. When that goes then that's more difficult.*
- *I know where my colleague is and I can pick up the phone but I didn't know that when I first started here.*

One receiving SLT compared her situation unfavourably with her adult physiotherapy-team colleague, who had good access to school staff via the school physiotherapist:

- *I watch my physiotherapy colleague - close colleague - who in the same circumstance [transition] would have phoned the school physiotherapist and they would have been working jointly - going to visit the parents, the school therapist introducing the adult one - 'Here's my colleague.' ' Passing over to you - here's the information.' It would have reduced the mother's anxiety.*

Discussion

Sustaining good provision is difficult when discontinuity, here due to planned school leaving, is inevitable. The SLT interviewees shared professional knowledge and values, and an employer, but the critical incident analysis uncovered systemic difficulties in co-working. These were not reported as service capacity limits. SLT teams were small, and some had staffing shortfalls and long-term absences. National trends showed SLT workforce numbers were not increasing (NES, 2013) whereas more individuals were being identified as having additional support needs (ASN) (Riddell and Weedon, 2016). There was a possibility that interviewees' case-loads were growing, but neither SLT service limits nor waiting list constraints were raised as themes by interviewees.

The difficulties reported related largely to information exchange. This involved confusion around referrals, as illustrated by the quotation about potentially inappropriate referrals coming through social work; different understandings about the roles of child and adult SLT teams, illustrated by reference to difficulties attributed to episodic working and 'discharged' school-leavers, and cumbersome access to older records.

The five child and adult SLT teams were differently line-managed, and served different districts and individuals with different clinical conditions. They had been created at different times, had altered their remits over time, and had been affected by

HB boundary changes and changes in NHS partnership structures. Details of their current composition were not readily available: neither the researchers nor the SLT participants and professional leads approached at the start of the study could locate a definitive list of relevant SLT teams with their contacts and remits.

This lack of outward facing, public information from the study HB was striking. Difficulties in identifying and locating relevant SLT teams would affect potential service users and referral agents.

They may not be able to identify who to refer to, and how, or what SLT services were available. Dangers around mis-managed referrals were considered most acute when the school-leaver had swallowing difficulties, but it is not certain that all named persons would understand the implications of these, or even associate them with a need for SLT service.

Extensive and principled multi-agency legislation, policy and guidance in Scotland, including a clear process of timely alerts and planning for school leavers and the appointment of a named person, had not it appears always been sufficient to ensure that transitions progressed smoothly. Some respondents related this to different models of practice in education and health services. Although the two approaches are not inimical, schools in effect have an on-going duty of care, whereas the routine health service model involves episodes of intervention being opened and closed. Pupils with SLSC needs were frequently not active SLT 'cases' at school-leaving, and re-referral to SLT services was required. Some respondents suspected that schools may not quite understand the issues, which as the SLT quoted above said was *'quite a complex one to get over'* to schools.

However, policies and guidance are designed to ensure all pupils receive consideration at school leaving by identifying a senior 'named person' to organize co- professional liaison for pupils with additional support needs of all types. As stated above, the number of pupils with ASNs has increased and children are routinely educated in mainstream schools. A recent Children and Young People (Scotland) Act (SG, 2014) further enjoinders LAs and health boards to deliver multi-agency approaches to promote the wellbeing of all children, and allocates a named person to each child and young person in Scotland. Therefore a large number of school senior staff will require to understand the specific responsibilities of being a named person, including for school leavers with SLSC needs. For this to be helpful, an understanding of such needs, of service models, and of appropriate collaborative action is required. Training in this for the large number of school staff who will become named persons is probably required. SLTs have no managerial role in education, and ways in which schools and SLTs can engage in forward planning for school leavers require to be addressed via both HB and EA decision makers. The difficulties in access to SLT services and the

cross-sector complexities in providing services for adults post-school identified by the *Keys to Life* strategy (SG, 2013) were not followed by an action plan, but this study suggests that such is needed. SLTs in this study reported dealing with transitions on an informal basis, and coping with problems on a pupil-by-pupil basis, rather than producing transition and care pathways with information for referrers and those wishing to access the service. Indeed, SLTs had in some cases abandoned former locally-developed transition procedures designed to alert schools to the need for a re-assessment of SLSC needs at school leaving. The abandonment of these procedures may have made further work in developing transition documents unrewarding to SLTs, although one team was in fact considering re/introducing similar procedures. However, placing a 'flag' on a pupil's file on discharge from SLT service recommending that a future named person (re)- refers when school leaving is planned would be welcome. Criteria for identifying pupils for whom an SLT referral is usually anticipated are also needed: having difficulty swallowing and reliance on alternative communication devices were amongst the factors raised by respondents. SLTs may also require to explain that 'discharged' is a child's current SLT status, to be overturned if necessary by a referral for a needs assessment, and not a final decision on access to SLT service.

Once a referral was received by an adult SLT team, local knowledge often meant they could often identify which child SLT team had had previous contact with the school-leaver, and request previous therapy information. At the time of the research this imposed '*bureaucratic*' burdens both on those requesting and those retrieving the information. Better direct access to electronic health records was on-going, and was predicted to improve the situation, allowing adult SLT teams direct access to information.

The study elicited comments from individual SLTs showing they used established social capital relationships where possible to bridge across SLT teams, and, as the illustrative quotes suggest, found this helpful. Forbes and McCartney (2010, 2012) discuss the value of cross-team bridging forms of social capital in enhancing mutual trust and respect amongst children's services staff, supporting co-working by augmenting within-team bonding social capital relations. However, SLTs

noted that relationships promoting social capital were personal, and easily disrupted by staff and location changes. No attempts at team building were reported. This suggests that

benefits from positive social capital relationships will be inequitably distributed across SLTs, and hence across school-leavers. If positive social capital relationships are seen as desirable and protective factors in co-professional working, HB management could acknowledge this and attempt to develop appropriate professional support networks across SLT teams.

Towards better transitions

Potential improvements to many of the issues raised were suggested by participating SLTs. Extension of access to electronic records is ongoing within the HB, and a new cross-team SLT professional lead has been appointed. Some issues require to be addressed by school and educational staff, in particular regarding the expected role of the pupil's named person.

Additional points arise from the study and relate specifically to SLTs. It is suggested that:

- information on SLT teams, their remits, the scale and nature of their services, their referral procedures and team contacts should become readily accessible;
- transition procedures should be written, and widely disseminated across education as well as health and social services staff;
- information common to many individual transitions should be specified, published, and widely shared;
- pupils' school records should be flagged by child SLT teams on discharge from SLT if re-assessment of need is likely to be required on leaving school. This is particularly likely if the pupil uses communication technological devices or has swallowing difficulties.
- further implementation studies consider the breadth and realities of co-working practices.

Conclusions

The study is small scale, as SLT teams are few and small, and is from one HB. It does not report the views of non-SLT professionals, or of school leavers and their families. It uses critical incident methodology to retrospectively evaluate successful and less successful factors within transitions, and does not report on typical practice. However it identified themes that are likely be relevant to other SLT services. It raised implications for school-leavers' policy development and implementation across Scotland and the UK, in terms of clarifying models and procedures, and for individuals with disabilities who require information to access services smoothly across transition points. It indicates the need for further implementation research into real-world professional practice to inform managerial process reviews and support the construction of robust planned transition pathways. Such research should consider professionals' views of policy implementation along with the views of clients and carers.

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Conflict of interest.

The authors report no conflict of interest.

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